



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

PINE CREEK MEDICAL CENTER  
9032 HARRY HINES BLVD  
DALLAS TX 75235

#### **Respondent Name**

WEST AMERICAN INSURANCE CO

#### **Carrier's Austin Representative Box**

#01

#### **MFDR Tracking Number**

M4-10-3776-01

#### **MFDR Date Received**

APRIL 28, 2010

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The disputed fees should be paid in accordance with TDI-DWC §134.404. Hospital Facility Fee Guideline – Inpatient...Carrier failed to notify HCP of any contractual agreement, therefore, we request that this claim be paid in accordance with TDI-DWC Medical Fee Guidelines..."

**Amount in Dispute:** \$15,238.08

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "This is a network claim. Charges were reduced in accordance with the terms of the network contract."

**Response Submitted by:** America First Insurance Co., P. O. Box 833902, Richardson, TX 75083

### **SUMMARY OF FINDINGS**

| Dates of Service                          | Disputed Services                    | Amount In Dispute | Amount Due  |
|---|--------------------------------------|-------------------|-------------|
| June 11, 2009<br>Through<br>June 12, 2009 | Inpatient Hospital Surgical Services | \$15,238.08       | \$13,827.94 |

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated August 3, 2009

- 45 — Charge exceeds fee schedule/maximum allowable or contracted legislated fee arrangement. (Use

- Group Codes PR or CO depending upon liability).
- W1 — Workers Compensation State Fee Schedule Adjustment.
- BILL NOTES** — THE IMPLANT INVOICES WERE NOT RECEIVED CORRECTLY WITH THE CERTIFIED STAMP AND SIGNATURE ON EACH INVOICE, THEREFORE, THE IMPLANT CHARGES WERE ALL INCLUSIVE WITH THE DRG ALLOWANCE. DUE TO THE TDI-DWC RULE #134.404 G 1, A FACILITY OR SURGICAL IMPLANT PROVIDER BILLING SEPARATELY FOR AN IMPLANTABLE SHALL INCLUDE WITH THE ORIGINAL BILLING A CERTIFICATION THAT THE AMOUNT BILLED REPRESENTS THE ACTUAL COSTS (NET AMOUNT, EXCLUSIVE OF REBATES AND DISCOUNTS) FOR THE IMPLANTABLE. THE CERTIFICATION SHALL INCLUDE THE FOLLOWING SENTENCE, "I HEREBY CERTIFY UNDER PENALTY OF LAW THAT THE FOLLOWING IS THE TRUE AND CORRECT ACTUAL COST TO THE BEST OF MY KNOWLEDGE." THE STATEMENT MUST BE ON EVERY INVOICE AND MUST BE SIGNED.

Explanation of benefits dated August 6, 2009

- 18 — Duplicate claim/service.
- BILL NOTES** — THESE CHARGES ARE BEING RECONSIDERED UNDER THE ORIGINAL CASE# 8003-U-3686-1.

### **Issues**

1. Is the reduction code 45 supported?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

### **Findings**

1. The services in dispute were reduced or denied in part using adjustment *code 45 — Charge exceeds fee schedule/maximum allowable or contracted legislated fee arrangement*. Although the respondent in this case alleges that "charges were reduced in accordance with the terms of a network contract" it did not provide documentation to support that a contract exists between the parties, nor did it explain the type of contract that exists between the parties in dispute. The division cannot establish whether the requirements of applicable labor code and division rules such as Texas Labor Code §413.011, 28 Texas Administrative Code Rule §133.4, or Insurance Code Chapter 1305 were met. The division concludes that reduction code 45 is not supported.
2. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
  - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
  - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

3. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
  - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
    - (A) 143 percent; unless
    - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

4. §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission.

- (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Review of the documentation found supports that the following items were certified as required by (g):

| Itemized Statement Rev Code or Charge Code | Itemized Statement Description | Cost Invoice Description                           | # Units & Cost Per Unit  | Cost Invoice Amount         | <b>Per item</b> Add-on (cost +10% or \$1,000 whichever is less). |
|--|--------------------------------|--|--------------------------|-----------------------------|--|
| 278  | IMP DISTRAC PIN 12MM           | 12MM DISTRACTION PIN SS STERILE                    | 2 at<br>\$30.00<br>ea    | \$60.00                     | \$66.00  |
| 278  | IMP ALPH-SP DBM GEL, 5CC       | ALPHAGRAFT BONE MATRIX GEL 5CC                     | 1 at<br>\$685.00<br>ea   | \$685.00                    | \$753.50   |
| 278  | IMP ALPH-SP PLT 32MM TRESTLE   | ANTERIOR CERVICAL PLATE LVL 2, ASSY, 32MM, TI      | 1 at<br>\$1,980.00<br>ea | \$1,980.00                  | \$2,178.00   |
| 278  | IMP ALPH-SP PROFUSE LG         | ALPHAGRAFT PROFUSE, BLOCK L13MM X W11MM X H11MM    | 2 at<br>\$1,000.00<br>ea | \$2,000.00                  | \$2,200.00   |
| 278  | IMP ALPH-SP CAGE 6MM XS M-5    | NOVEL XS M-5, 6MM, PEEK                            | 1 at<br>\$2,115.00<br>ea | \$2,115.00                  | \$2,326.50   |
| 278  | IMP ALPH-SP CAGE 7MM XS M-5    | NOVEL XS M-5, 7MM, PEEK                            | 1 at<br>\$2,115.00<br>ea | \$2,115.00                  | \$2,326.50   |
| 278  | IMP SLPH-SP SCR 4.0 X 12MM     | 4.0MM VARIABLE ANGLE SELF-DRILLING SCREW, 12MM, TI | 2 at<br>\$395.00<br>ea   | \$790.00                    | \$869.00   |
| 278  | IMP ALPH-SP SCR 4.0 X 14MM     | 4.0MM VARIABLE ANGLE SELF-DRILLING SCREW, 14MM, TI | 4 at<br>\$395.00<br>ea   | \$1,580.00                  | \$1,738.00   |
|  |                                |  |                          | \$11,325.00                 | \$12,457.50  |
|  |                                |  |                          | <b>Total Supported Cost</b> | <b>Sum of Per-Item Add-on</b>                                    |

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

5. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, **plus** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at <http://www.cms.gov>, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

- Documentation found supports that the DRG assigned to the services in dispute is DRG 473, and that the services were provided at Pine Creek Medical Center. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of

\$12,280.77. This amount multiplied by 108% results in an allowable of \$13,263.23.

- The total cost for implantables from the table above is \$11,325.00. The sum of the per-billed-item add-ons does not exceed the \$2000 allowed by rule; for that reason, total allowable amount for implantables is \$11,325.00 plus 10% (\$1,132.50), which equals \$12,457.50.

Therefore, the total allowable reimbursement for the services in dispute is \$13,263.23 plus \$12,457.50, which equals \$25,720.73. The respondent issued payment in the amount of \$11,892.79. Based upon the documentation submitted additional reimbursement in the amount of \$13,827.94 is recommended.

### **Conclusion**

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$13,827.94 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

|                    |   |                                 |
|--------------------|---|---------------------------------|
| _____<br>Signature | _____<br>Medical Fee Dispute Resolution Officer | _____<br>March 21, 2013<br>Date |
| _____<br>Signature | _____<br>Medical Fee Dispute Resolution Manager | _____<br>March 21, 2013<br>Date |

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**